SURGICAL DISEASES OF WOMEN.

BY

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OF JOLIET, ILL.

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Restoration of the Perineum.

CASE 1.—Mrs. ——, aged twenty-six years. Three years before I saw her, this lady was delivered of a hydrocephalic child—a still birth. The feet presented, and forceps were applied to the head, effecting its delivery, with the result of producing a complete laceration of the perineal body, and of the septum through the sphincters. From date of the injury this lady experienced the usual sequent miseries of this injury. She had no voluntary control over the sphincter function of the bowel, and had prolapse of the bladder. She was confined to the house, and generally to the bed. During this time she lost weight and color, and began to cough, and had chills and night sweats. Her mother having died at an early age with consumption, this disease was reasonably feared by the patient and her friends, in her own case. I was called to see her on account of her lung disease, and found a condition of her right lung which, I believed, indicated fibrous phthisis. She told me nothing about her injury until the fact was developed by inquiries relating to the uterine organs. On examination, I found the condition as stated. I advised the patient to have the perineum restored by operation, and afterward to take a trip to Colorado, for her lungs, to which she and her friends assented. In the surgical treatment of this case I followed the method practiced and advised by Dr. T. H. Emmett in his truly great work on gynæcology. As a preparation, locally, for the operation, vaginal injections of hot water were used daily for about two weeks, and sesquioxide of iron was given internally.

On the fourth day before the operation a laxative was given, which was repeated daily, the last dose being given the evening before. The intestines were as empty as they could be made, which plan is most decidedly a great improvement over the old one of giving a cathartic only the day before the operation. At six o'clock in the morning two grains of opium were given, and at nine o'clock the operation was performed.

The patient took ether very kindly, and when under its influence I removed the cicatricial tissue and as much of the vaginal mucous membrane as was deemed necessary. The rent in the septum was so great that the apex of the denudation in the mucous membrane was well up in the *cul de sac* behind the cervix. During this part of the operation the bleeding was excessive, several vessels being cut, and the capillary bleeding being greater than was expected after the prolonged use of hot water. I have since learned enough to know that the sesquioxide of iron contributed to this result, as it inhibits the vasomotor contractors, and I have lately used it in angina with better success than is given by nitrite of amyl. To control the bleeding, hot water was used by one of the assistants, at first with a sponge, and then with a syringe. The two physicians who assisted in the operation and I, soon learned to keep a stream of hot water following the cut of the scissors; but for this the operation would have been almost impossible. The

surface denuded was unusually large, and eight silver sutures were used. The first suture was placed in that relation to the sphincter which insures its union, and which was demonstrated by Dr. Emmett, and is difficult to explain without the aid of the diagram given in his book.

The last suture was inserted through the vulva and passed through the mucous membrane above the denuded surface, which drew the membrane over the vaginal portion of the surfaces where union was hoped for. The placing of the lower and upper sutures in this manner, with the object of placing the torn edges of the sphincter in apposition in one case, and of protecting the uniting surface from the septic influence of vaginal biological ashes in the other, are certainly strokes of a gynæcological genius.

On the sixth day after operation the two middle sutures were removed; the remainder were removed on the twelfth day, and the union was perfect. Injections were given, to render the contents of bowels soluble, and they were moved without injury. During the twelve days, one-half a grain of opium was given daily, which was sufficient to prevent any action of the bowels, and vaginal douches, carbolized, were also used daily, and the urine drawn twice a day, great care being used to avoid getting any urine into the wound.

The general health of the patient began to mend as soon as she was out of bed. She gained flesh, got a good color, and went to Colorado for six months. The lung disease was subdued, so far as any active manifestation goes. It is now three years since the operation was made; the lady during this time has again become a mother, with very little injury to the perineum, and her health is good.

Case. 2.—Mrs. —, was aged twenty two years when she was delivered of her first child. Her *accoucheur* was a member of the hybrid, homœopathic, "new school" of medicine. The perineal body, as a result of this labor, was torn through, as well as the external sphincter muscle. The sequences of the injury were: A limited control over the sphincter function, and prolapse of the uterus, the cervix of which was somewhat lacerated. The patient attributed her misfortune entirely to the fact that her physician during the bearing down pains kept straining the perineum backward with his fingers. On questioning her, I learned that she was delivered while lying on her left side, with thighs flexed, which position, combined with the efforts of her physician, were certainly proper antecedents to such a calamity.

I wish here to contribute a mite toward the literature of management of the perineum during labor. It is obvious that the perineum serves a purpose in the mechanism of labor, and other things being equal, does not require the support so much talked about in the text books. The benefit of such support—pressure with the hand—having the effect to aid the perineum in giving the head a forward direction, describing a curve around the pubis. It is apparent that if this direction of the head is maintained there is so much less danger to the perineum. The course of the head through the pelvis, in the direction of the curve of Carus, is in great part due to the anatomical conformity of the pelvis; but the office of the perineum is to continue the course of the head in the circle of which the curve of Carus is a segment, and the opposing force to this perineal force is the pubis. It is, then, a deduction from these facts, that support of the perineum means aiding the perineum to continue the course of the head in the direction of a circle which is continuous with the curve of the pelvis. It is a further deduction, that straining the perineum in the opposite direction directly interferes with the mechanism of labor, and as directly endangers the perineum. Another factor in the support of the perineum is the position of the parturient woman. It may easily be demonstrated that the woman, when the head is describing the curve around the pubis, should lie with her thighs extended. If the finger of the *accoucheur* be inserted between the head of the child and the perineum, and the woman's thighs are flexed, the tension of the perineum is felt to be greater than when the thighs are extended, other things being equal. If this demonstration proves anything, it is, that flexure of the thighs upon the abdomen increases the curve of Carus very notably in that portion of its course bounded by the perineum, and that flexion of the thighs during delivery of the head and shoulders directly increases the danger to the perineum. I have never attended a parturient woman who suffered rupture of the perineal body to any notable extent, which fact I attribute to the reason that I discovered the facts as given, relating to flexion of the thighs and tension of the perineum, in the third case of labor which I attended, sixteen years ago—a primipara, thirty-eight years of age, during whose labor the head remained two hours in a position which partially distended the perineum. This discovery, I suppose, has been made by many physicians, but I never happened to see the record of it.

In this case the operation for restoration of the

perineum was made by the older method. Instead of cutting away the cicatricial tissue and the mucous membrane, the epithelial tissue only was removed and the silk quill suture used. The union was not as complete as in Case 1. To all appearance, as manifest to touch, the perineal body was intact; but a communication existed between the vagina and external perineum, along which water could find its way when injected into the vagina. The patient, however, was cured, by the operation, of the prolapsus and the inconvenience relating to the bowel.

Restoration of Cervix.

Case 3.—Mrs. —, when I saw her, in February, 1880, was forty-two years old and the mother of five children, the youngest seven years of age. This lady is a native of England, and her physician in London was the famous Dr. Richardson. I was called to see this patient on account of an attack of menorrhagia. I made no examination, as the proposition to do so was thought by her to be unnecessary, as she stated these attacks had been repeating themselves at intervals during the last two years, and she thought they were due to approaching change of life. I prescribed large hot water vaginal injections and a preparation of ergot and digitalis, to be taken in a decoction of cinnamon.

In two weeks I saw patient again, and was obliged to use the tampon. I discovered, by digital examination at this time, that she had a complete laceration of cervix. I found it necessary to tampon vagina several days, and learned by repeated examinations that the cervix was split entirely, and its lateral halves were, so far as could be determined by touch, continuous with the vaginal walls. I confess that I was nonplussed by the case as felt at first, for, sliding my finger up the vaginal wall, I would find no evidence of a cervix, or Douglas *cul de sac*, but my finger would pass up into the cavity of the uterus, which fitted it like a cup thimble. I had never seen a laceration so extensive, and was unprepared to know the meaning of the tactile sensation. I became satisfied, however, what the condition of things must be, and in a few days, the bleeding having ceased, I made an examination with Sim's speculum, and found that I could see the fundus uteri, as well as feel it, there being no external or internal os. With two hooks I brought the halves of the cervix from, apparently, out of the vaginal walls, and drawing them together the form of the uterus could be seen. The perineal body was also lacerated, and the fundus of the uterus—the inside of it—was about three inches above the vulva. I explained the nature of things to the patient, who remarked that Dr. Richardson said she was ruptured, and had proposed an operation to relieve her before she left London. The cervical mucous membrane was congested, and pricking it let out an abundance of gelatinous substance.

I told the patient that her life depended on the restoration of the cervix, and two months were occupied in the preparatory treatment and unavoidable delays. The treatment consisted in administration of ergot, digitalis, and dialysed iron; a daily vaginal douche of a gallon of hot water, and application every third day of compound tinct. of iodine to the cervical membrane and uterine cavity. There were frequent and severe hemorrhages during this period of preparation, and for twenty days, in the aggregate, I was obliged to use the tampon. A notable feature of this treatment was the hot water injections, which were performed with the ordinary Davidson's syringe, using one gallon of water at once, and which was, of course, injected directly into the uterine cavity, without a symptom of the usual uterine colic which follows sometimes the advent of a small quantity of water into the uterus. There was apparently no more sensation, in character or degree, in this patient's uterus than was afforded by the vaginal walls. The patient could distinguish her menstrual hemorrhage from other paroxysms of bleeding by the backache and other sympathetic pains, and the operation was appointed on the fifth day after accession of menses, providing the flow could be stopped. At next menstruation she was tamponed, as usual, and seven days passed before she was ready. At this time a physician sent her word that he could cure her without an operation, and in consequence the operation was delayed until ten days before the time for her next menstrual period. The operation was made as Emmett directs: the cicatricial and mucous membrane being removed, leaving a space for the cervical canal, the two halves were brought together, and eight silver sutures were used. On the fourth day after the operation she began to flow, which I supposed would destroy the hoped-for result of the operation. The flow continued about six days. I left the sutures in place fourteen days, hoping union might occur, when the patient had an attack of winter cholera, which came on at night, was very severe, and when I reached her she was collapsed, almost pulseless, and was, to all appearances, a hopeless case. Her family and friends were around her in the attitude of mourners, and I never saw so pale and exsanguined a surface

as she presented. I gave her, hypodermically, morphia sulph. gr. $\frac{1}{4}$ and atropia sulph. gr. $\frac{1}{70}$, the remedy which I relied on for winter cholera. She began within an hour to rally, and recovered from the attack. She was plied with beef extract and brandy until the eighteenth day from date of operation, when I removed the sutures, fully expecting to see the parts separate, but to my great surprise the union was perfect. At her next menstruation the patient declared she was "more natural than she had been at any time since she was twenty years old." She has been healthy ever since and has gained thirty pounds in weight. The uterus occupies the normal position in the pelvis, notwithstanding the perineal body is gone.

CASE 4.—Mrs. —, was married at the age of thirty-eight years. She was small in stature, light in weight, had always been a subject of neurasthenia, with neuralgic manifestations, but never had any of the zymotic diseases, or acute sickness, and yet says she never had a well day.

Within a year after her marriage this lady was delivered of a ten pound boy, by aid of forceps, and the cervix was completely lacerated. In this case the split was not midway in the cervix, but the anterior portion was about half the thickness of the posterior. The two sides rolled out, after the manner of a celery root when split in the axis of its length. The laceration extended upward on the external surface of the cervix to its junction with the vaginal walls, and internally extended through the internal os. The sequences of this injury were entirely referred to the nervous system, and the only discomfort was neuralgia, which appeared to extend throughout the whole sensory nervous system connected with the pelvis. The pain was nearly constant, and confined her to bed. Sleep could only be procured after great exhaustion from wakefulness and suffering, or by chloral. At the end of the second month the cervix was restored by the same method as in the previous case, but without an untoward symptom. The sutures were removed on the tenth day and the union was found perfect. The restoration of the cervix cured the pelvic neuralgia, and her general health is much better than before her marriage.

CASE 5.—Mrs. — was twenty-eight years old when she was delivered of her first child, by forceps, with the lamentable sequence of unilateral laceration of the cervix and complete rupture of the perineum. Her physician told her that the accident was due to the fact that the child had no soft spot in its head. I suppose he referred to the condition of the fontanelles. He, however, immediately inserted silver sutures, and to all appearance the perineum was united, and the medical gentleman assured the patient that the like was never known before. I saw the case three months afterward. The patient was emaciated, had loss of appetite, indigestion, and the urine loaded with phosphates. She referred her local distress to the bladder, stating she not only had difficult micturition, but could not sit, except on one of the nates, or rather one hip, frequently changing from one side to the other, on account of painful sensations produced in the bladder.

On examination, I found that the perineal body was not united, but there was a union of the integument of the perineum, which bridged across the chasm, and somewhat resembled the web of a goose's foot. The uterus emitted a discharge of acrid, purulent matter, and was prolapsed, resting between the severed halves of the perineal body. To relieve the sensation of bladder distress I cut the bridge away with scissors, which allowed the patient to sit upright, by removing the tension from the integumentary perineum, and proceeded to prepare her for restoration of cervix and perineal body. These operations were completed in due time, without misfortune or hindrance, and the patient recovered her health. She has since given birth to her second child, during the labor for which the perineum remained intact.

CASE 6.—Mrs. —, when I saw her, was aged nineteen years; had been married three years; and a year since gave birth to a child. Since then her health had materially deteriorated. She was subject to hystero-epilepsy, and was at times quite maniacal. There was a bellows murmur, heard loudest over the apex of the heart. She never had rheumatism She complained of an acrid vaginal discharge, which caused great irritation, and had been treated for ulceration of the cervix, without benefit. I detected a unilateral laceration of the cervix by digital examination, there being so much vaginal inflammation that I could not use a speculum. She was directed to use hot water vaginal douches, and returning in two weeks, a speculum examination was made, which verified the existence of the laceration. The lacerated surfaces were secreting pus of an acrid character, which kept the vaginal mucous membrane in a condition of inflammation. Topical applications of the comp. tinct. of iodine were made daily to the wound, and punctures with a sharp lancet as often, to let out the gelatinous matter. The parts appearing ready for the operation, the day was

appointed, but while getting ready, owing to excitement, the patient had an attack of hystero-epilepsy, which postponed matters. This occurred the second time, when I adopted the strategic move of making the operation without foreknowledge on her part. The patient was placed, as usual during her local treatment, in Sim's position. I quickly denuded the surface, but trouble began in patient's head before I could insert the sutures. I took a cup pessary, and applying it over the cervix, packed the vagina with a cotton tampon, fixing thereby the stem of the pessary. The patient was accustomed to applications of cotton glyceroles, and with additional persuasion became quiet. The next day she was informed of the condition of matters, and remained quiet in bed. Every other day I removed and replaced the cotton tampon, carefully keeping the cup pessary in place by holding the stem. This procedure was kept up for ten days, when I ventured to look at the cervix, and had no reason to be dissatisfied with the result. The surfaces were united. The patient was put on increasing doses of bromide of zinc, which, together with a change of climate, worked a cure.